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PREVENTION OF EMOTIONAL AND BEHAVIORAL DISTURBANCES*

HENRY C. SCHUMACHER, M.D., Chief
Mental Health Services, San Francisco
Regional Office, U.S. Public Health Service

I appreciate the opportunity to talk with you about prevention—prevention not only of psychotic states, but also of the many other types of emotional and behavioral disturbances. We sometimes forget that the psychoses are but as a drop in the bucket compared to the total volume of emotional and behavioral disturbances. Our own attitude toward the problem of the mentally ill, that is, the psychotic, which is one of anxiety and even fear and dread, probably is the reason that this group of disorders concern us much more than their total number really warrants. In a certain sense this is true also of those persons who are institutionalized in prisons and correctional schools. Society—and we are a part of it—insists that certain kinds of mental and behavioral disorders be institutionalized. Undoubtedly, many of those today in the mental hospital, the prison, and the correctional camp and school could be more adequately cared for outside the institution.

In the case of the mentally ill, society feels that those who are dangerous to self, or to others, or a social menace to the community, must be institutionalized. But of the total number of hospitalized psychotic patients only perhaps one out of four are of that kind. To be sure, others may profit from the treatment received. Yet, the question can well be raised, is the State hospital the only or even the most desirable place for them to receive such treatment? As you may know, a grant has been made to the Department of Mental Hygiene for the purpose of trying to determine what kinds of patients can be cared for as well, or better, in an extramural setting who now must go to mental hospitals. At the present time there is little factual data concerning this problem, but such evidence as we have would seem to indicate that this may be as many as two, or possibly three, out of every four now committed to mental hospitals. I am sure that those of you working in the adult and juvenile correctional fields are also quite aware that entirely too many persons are sent to institutions; or put in other words, that many of these persons now institutionalized could be cared for in the community with as good and probably better end results.

But now to come specifically to prevention. This can be divided into primary prevention and secondary prevention or control. Secondary prevention or control aims at early treatment and preventing relapse, or keeping the condition from getting worse, that is, becoming hazardous to self or others.

Primary Prevention

Unfortunately, there seems to be a commonly held belief that we know nothing at all about primary prevention. All too often those who ought to know better have made such unjustified statements. Let us look at the record. Pellagra and pernicious anemia formerly brought many patients to the mental hospital. Lead and other heavy metal encephalitic states are today practically unknown to mental hospitals. The traumatic psychoses have been greatly reduced: So also the post-infectious disease psychotic states, of which syphilitic psychotic states are excellent examples. Neither does one see the former frequency of post-partum psychotic states. In the field of mental subnormality there too has been much progress in primary prevention. Particularly is this true of such states as are determined by the circumstances of pregnancy, such as maternal rubella and rhesus and other blood factor incompatibilities. The incidence of subnormality due to traumatic conditions due to birth or accident, as well as post-natal subnormality resulting from such causes as lead encephalopathy, and other infectious meningitic and encephalitic states has been lowered.

Unfortunately, all that today is known about causation is not put into practice in any of the fields of emotional and behavioral disturbances. This is particularly true in the field of psychological and cultural causation. For example, in the field of obstetrics much more could be done in counselling not only the pregnant woman but also her husband. Fears, worries and anxieties, some on deep-seated psychological grounds, others more strictly culturally determined haunt the prospective parents. The Antioch studies as well as others are throwing light on the profound hormonal and nutritional disturbances so caused. Then, too, such psychological and cultural conditioned disturbances are often the reasons for the attempts at interrupting the pregnancy. Such disturbances may have a bearing on the problem of prematurity. Instead

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of falling back on genetics and heredity as an explanation for the disturbed behavior of the infant, it would be much better to attempt to deal with the psychological and cultural disturbances of the pregnant woman.

We also know that certain things are still happening at the time of delivery which need not happen. Some of these things are quite definitely culturally determined; for example, the demand of the modern woman for a complete loss of recognition that she had anything to do with the birth. So does this by demanding a lot of anesthesia which, in turn, may create a serious problem for the child about to be born. Now, I am not unaware that there are a lot of pros and cons as to the effect of anoxia, but I think there is some good evidence to show that it makes a difference. It can be shown in rat experiments that the amount of oxygen, and particularly the *timing* of the amount of oxygen, is an extremely important matter.

Knowledge Into Practice

So prevention implies that these bits of knowledge, some of them still quite imperfect to be sure, but nevertheless applicable and of value at the moment, be really put into practice by those who have concern with that problem, in this instance by the obstetrician. Attention to the physical organic factors in pregnancy is not enough. The obstetrician needs to be better informed about and trained in his task of dealing with the total patient and the situation in which the patient finds herself.

Now, coming to the post-natal period, the facts are that many women, and men too, are asking for help and guidance about their own confused state in the rearing of children. But only to a limited extent do they get help from the average practitioner. My point in making these remarks is not to be critical of the practitioners of medicine at all, but rather to point out that a better educational program for them is an important factor in prevention. This is up to those of us who from our fields of knowledge can make a contribution. They need to become aware of the role that they play in a preventive mental health program. This is to be no attempt to make them psychiatrists, but rather to sharpen up their perception of what can be done in their field of activity and to help and encourage them to practice it to the degree that you would expect the modernly trained specialist to do. He must be helped, too, to be aware of what is beyond his ability and when to refer it to someone more adequately trained. But certainly the pediatrician is in an unique position to help a mother with the problems she has. I am sure that you who have had experience in working in a well-child conference know well that if you give the mother an opportunity to talk she will bring out her psychological as well as her physical concerns regarding the child. The pediatrician must be taught how to listen in order to gain the confidence of the parent, for then only will he be told about the things in the family setting which are of real concern.

In this age when young couples mate whose cultural backgrounds are quite different, there is much concern about the rearing of the child. Whose culture pattern shall be followed, the wife's, the husband's, his parent's, her parent's? And when quarreling over this ensues, it is the child who suffers. Such disagreements over discipline, feeding, toilet training, etc., are common causes not only for warped emotional attitudes but also for psychosomatic disturbances in the child. Such parental conflicts over child rearing also affect the adults, and tension symptomatology is a common end result. Dynamic psychology has stressed the importance of these disturbed interpersonal relationships of parent and child and parent and parent. It would appear that sound counselling and guidance—psychotherapy if you will—by pediatrician and public health nurse would tend to prevent much of such emotional and physiological maladjustments.

Meeting Children's Needs

Modern society has made it necessary for many mothers to work outside their own homes. The work of Skeels, Spitz, Bowlby and others has shown the effect upon the child of a lack of mothering. Yet, the State of California over the last several years has debated whether there was a need for child-care centers. Not only is there need for such centers, but there is need for in-service training of the personnel who operate such centers in order that the needs of the children be satisfactorily met. Here, again, is a place for sound preventive work. There are other groups who are responsible for seeing that children's needs are met. Public welfare through its Aid for Dependent Children, for example, has thousands of children on its rolls. Unfortunately, the true philosophy of Social Security is not often practiced. The objective should be to put a floor under the family below which it is not economically to sink and then to provide such skilled services as to rehabilitate and to maintain normal development; social-emotional as well as physical. This requires competently trained social workers as basic staff. Since this is rarely the case at the present time, in-service training is essential. Here again the objective is prevention. The lack of that is well expressed in today's clamor for treatment institutions for children. I do not doubt the need at the present time for such facilities, due in great part to neglect and unskilled care. But I do doubt the wisdom of emphasizing such rehabilitative services at the expense of preventive work.

Now let us look at the school situation. Here again we have children and adults. Yet, the concern tends to focus on the children. The school staff —principals, supervisors, and teachers—is overlooked. But these adults frequently create problems for the children. The need to understand their own feelings and attitudes about children and the social milieu from which they come. School people tend to come from middle class culture homes. They frequently entertain the prejudices and biases of that group. All too often they find it difficult to accept certain kinds of behavior. They tend to meet it head on. This is one of the reasons why gangs are formed; namely, to revenge themselves on people who cause them to feel shame and who make them feel inferior. The point I wish to make is that the problems do not reside only in the child. In work with the schools it is necessary to work also with the teachers and principals about their own problems in relation to the child and often his parents too. Then, too, there are teacher-teacher problems and teacher-principal problems which require attention. Left uncared for, their disturbed feelings, often of hostility, will

be taken out on the children. Prevention work relates then to teacher selection, sound school organization, proper curriculum to meet the needs of each individual child and a thorough understanding of the subculture variants.

Once again I must emphasize the need to teach those who work in close relationship with others if prevention is to be practiced. I have illustrated that in regard to practitioners of medicine, public health nurses, parents, social workers, and school people. But the clergy, the peace officer, the probation and parole worker, the personnel officer, the job supervisor, and others who work in responsible roles with people must also be reached. Not only must they see the opportunity they have for preventive work, but they need to understand that their own feelings, biases and prejudices often stand between them and a job well done. It is much more important to reach these responsible people than to carry on the shot-gun type of effort most commonly practiced by Mental Health Associations.

Secondary Prevention

It is difficult to draw a hard and fast line between primary and secondary prevention. Secondary prevention concerns itself with an already identifiable problem. All to often one does not see the emotionally disturbed adult before damage has been done the child. Fortunately, however, many childrens' problems are deviations within the normal rather than aberrations from the normal. The child will need an opportunity to perceive his dynamic environment differently. This requires working with the adults primarily, although often work with the child is also required. Many of these problems can well be handled by social workers and clinical psychologists. Much depends on their training. They must know when the problem is beyond their competency and needs to be referred to the psychiatrist. But, I repeat, many of the problems do not require psychiatric care. It is one of the unfortunate end results in the seeking of professional status that too many social workers have become too highly specialized. Or probably I should say, they have forgotten they were *social* workers. Not all people who need help will seek it. Many will not come to offices for formal office interviews. Neither do they need to. But the situation in which they find themselves does need something done about it. Community organization can be a means to effect controls.

It is a mistake to assume that delinquent children, for example, all come from the homes of delinquent parents. A child of school age lives his life progressively more influenced by factors outside his home. He is often thrown into conflict because he cannot reconcile the values taught him in his own home with the values he feels are now necessary in order to save himself from insult, shame and feelings of difference and inferiority. To protect himself, he joins with others somewhat similarly motivated and seeks to revenge himself. The more he finds the world outside his home disturbing the greater the injustice seems to be. So school misgrading, teacher's objection to his lower culture status way of behaving such as his aggression and shoving people about, and peer culture rivalry, make school and often community a not very desirable place. Adding insult to injury is the failure to provide jobs for the 17-to 20-year-old group through which they could earn money and hopefully buy status and obtain stability. School and community need to tackle this problem or undoubtedly there will be a further increase in delinquency. The juvenile court as a community agency needs more and better trained probation officers. But above all, all of the community agencies need to work together each carrying out its own job but in a cooperative endeavor. And it must be a community project responsible to local level authority. Entirely too much time is misspent when local resources are only vaguely known and where there exists no local responsibility for the work which is to be done. Nowhere is this better shown than in the activity of those responsible for "after care," such as State probation and parole officers and the social workers responsible for the after care of mental hospital patients. Much sound secondary preventive work is vitiated as a result of the inability to follow through. The person returning from prison, correctional institution or hospital, returns to the same environmental situation which originally played perhaps a major role in his difficulties. The remarkable thing is the amount of success agencies do have under the trying conditions the work is done. I am sure every institutional official sometimes wonders whether he has the right person—the one he has or the one back home who is responsible directly or indirectly for this one's troubles. Some of those institutionalized realize this and refuse to go back home. As you know, it appears that there is a higher rate of return to the institution when the patient has no insight into his family and community situation.

It would appear then that secondary prevention implies recognition of these adverse family and community situations and a concerted effort to do something about them. One step in this direction would be not to remove the patient from the locale in which his behavior became abnormal. This implies treating the total person and his situation. Above all, it means that preventive endeavor demands that an educational program be carried on with those who have a responsibility for working with people.

Former State Health Officer, Dr. Dunshee, Dies in Phoenix

Dr. J. D. Dunshee, Director of the California State Department of Public Health from 1934 to 1935, died January 28th in Phoenix, Arizona, at the age of 71. Dr. Dunshee was appointed to the state health post by Governor James Rolph, Jr., on March 17, 1934, and prior to that had served as city health officer for Pasadena from 1929 to 1934. For seven years before that he was Director of the Division of Child Hygiene in the Los Angeles City Health Department.

Dr. Dunshee was State Director of Public Health in Idaho for two years after leaving California in 1935. He then moved to Phoenix to serve as Director of Local Health Administration and Communicable Disease Control in the Arizona Department of Health, from 1937 to 1944. In 1945 he served as Principal Medical Officer at the Poston Relocation Center in Western Arizona, retiring at the end of the war to live in Phoenix. He is survived by his wife and one son.

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David Singman, M.D., Berkeley.

Hospital Administration

Fred W. Moore, Administrator, Rideout Memorial Hospital, Marysville; Wm. W. Stadel, M.D., Director, Department of Medical Institutions, San Diego County General Hospital, San Diego; C. V. Thompson, M.D., Chief of Staff, Lodi Memorial Hospital, Lodi.

Mental Health

Kent Zimmerman, M.D., Children's Hospital of the East Bay, Oakland.

Parasitology

Herbert G. Johnstone, Ph.D., University of California School of Medicine, San Francisco.

Psychiatry

Norman Reider, M.D., Chief, Psychiatry Clinic, Mt. Zion Hospital, San Francisco; Charles W. Tidd, M.D., Department of Psychiatry, University of California Medical School, Los Angeles.

Rehabilitation

Paul Dietrich, Crippled Children's Society of Los Angeles County, Los Angeles; Andrew Marrin, Chief, Bureau of Vocational Rehabilitation, Division of Special Schools and Services, Department of Education, Sacramento; E. Meteer, San Francisco.

School Health

Emil Palmquist, M.D., Health Officer, Berkeley City Health Department, Berkeley.

Statistics

William R. Gaffey, Ph.D., School of Public Health, University of California, Berkeley.

Toxicology

Charles Hines, M.D., Ph.D., University of California Medical School, San Francisco.

Tuberculosis

Emil Bogen, M.D., Olive View Sanatorium, Olive View; Harold G. Trimble, M.D., Oakland.

CURATORS OF THE UNCLAIMED DEAD

Northern California

J. B. deC. Saunders, F.R.C.S., Professor of Anatomy, University of California School of Medicine, San Francisco.

Southern California

Paul R. Patek, Ph.D., Department of Anatomy, University of Southern California School of Medicine, Los Angeles.

Veterinary Medicine

Donald Jasper, D.V.M., Dean, School of Veterinary Medicine, University of California, Davis.

Virus Laboratory

Irving J. Gordon, M.D., Professor and Chairman of the Department of Microbiology, University of Southern California, Los Angeles; A. F. Rasmussen, M.D., Professor of Virology, University of California Medical School, Los Angeles.

Health Officer Changes

Fresno County

Coalinga: The City of Coalinga is now served by the Fresno County Health Department under Dr. Robert D. Monlux. The former Coalinga health officer was Dr. Merle M. Edgerton.

Tehama County

Dr. Lynn E. Wolfe, Jr. was appointed Tehama County Health Officer on January 3, succeeding Dr. Charles R. Milford.

State Sanitarians' Association Plans April Symposium

Plans are under way by the California Association of Sanitarians to hold its annual symposium in Long Beach on April 27th and 28th. The Association's board of directors met January 27th at the San Luis Obispo County Health Department to discuss preparations for the symposium and to carry out other organizational work for 1956.

Edwin A. Watkins, San Diego Health Department, is the 1956 president of the association. Other members of the board of directors are: Edward V. Bondolfi, Vice President, Alameda County Health Department; Jordan F. Hiratzka, Secretary, University of California; Maurice B. Hawkins, Treasurer, Riverside County Health Department; Alfred Ray, President, Northern California Chapter, C.A.S.; Seymour Barfied, President, Southern California Chapter, C.A.S.; Lloyd Irons, President, Citrus Chapter, C.A.S.; and Earl E. Hansen, President, Central California Chapter, C.A.S.

Junior Chambers of Commerce Sponsor Community Health Week

Again this year Community Health Week, March 18-25, will be sponsored by the U. S. Junior Chamber of Commerce in cooperation with the National Health Council. Some 2,800 local Jaycee chapters across the nation are being urged to conduct Community Health Week activities that will offer:

- a valuable experience in cooperative action for health groups;
- a focus for gaining interest and support of the community in essential services for health improvement;
- a device for developing and discovering new health leadership; and
- new community support for official and voluntary agency programs.

Health councils have been urged to lend their support to this program and the American Medical Association has advised its component societies of the program and urged them to consider local implementation. The National Dairy Council has also recommended cooperation of its affiliated units. The National Health Council emphasizes that cooperation of state and local health departments is essential to the success of this nation-wide endeavor.

Control of Communicable Diseases Outlined in Revised Manual

The third revision of the California Manual for the Control of Communicable Diseases containing state control regulations and laws and technical material regarding each of the reportable diseases has just been published.

The manual contains specific information concerning the occurrence of reportable diseases in California, public health nursing responsibilities, laboratory services available in the State and other pertinent information. It is distributed to private practicing physicians, hospital nursing staffs, local health jurisdictions, medical schools, schools of nursing, libraries and to interested persons in allied, non-official health organizations.

Public Health Positions

Contra Costa County

Dental Hygienist: Salary range $374-$449. Valid license as dental hygienist issued by the State Board of Dental Examiners required. Education and Experience: Either (1) Completion of four years in a curriculum of dental hygiene at an approved university; or (2) A two-year course in dental hygiene, with at least two years of practical experience, of which one year shall have been in a school or health or welfare department dental program.

Supervising Public Health Nurse, Grade I: Salary range, $429-$515. Registration as Public Health Nurse in the State of California required. Education: Graduation from accredited school of nursing and possession of a Bachelor's Degree from college or university of recognized standing. Experience: At least three years of public health nursing experience. (One year full-time graduate training in public health may be substituted for one year of the required experience.)

Medical Care Assistant: Salary range, $429 to $515. Education: Graduation from a college or university of recognized standing. Experience: Two years of full-time paid experience in a program of medical care in a hospital, social agency or health department, including one year in a supervisory or administrative capacity. (Additional qualifying experience may be substituted for the required education on a year-for-year basis up to a maximum of four years.)

Applications and additional information can be obtained from the Contra Costa County Civil Service Commission Office, Room 229, Hall of Records, Martinez.

Humboldt-Del Norte County

Sanitarian: Salary range, $332-$392, with starting step depending on experience. State certificate of registration required. Car furnished. For further information write to Director of Public Health, Humboldt-Del Norte County Health Department, 805 Sixth Street, Eureka.

Pasadena

Sanitarian: Salary range, $362-$441, dependent on training and experience. Requirements. Possession of a California State Certificate as a Registered Sanitarian. Apply Personnel Department, City Hall, Pasadena, California.

Diphtheria Outbreak in Tulare

Fourteen cases of diphtheria, including one death, were reported in Tulare County between November 6th and December 12th, with the outbreak focused in residents of farm labor center housing area and the small neighboring community of Farmersville.

No evidence of common source infection could be found. Most of the cases were mild—only two were classified clinically as moderate and two as severe.

The State Department of Public Health assisted the Tulare County Health Department in the epidemiologic investigation.

San Diego County

Dentist: Salary range, $647-$679. Immediate opening in San Diego Department of Public Health for dentist who likes to work with children. To work in well-equipped dental trailer in schools in rural areas. Apply Department of Civil Service and Personnel, Room 402, Civic Center, San Diego.

Santa Barbara County

Public Health Analyst-Business Manager: Starting salary $338 or higher, depending upon background and qualifications. Car furnished. Contact Joseph T. Nardo, M.D., M.P.H., Health Officer, Santa Barbara County Health Department, P. O. Box 119, Santa Barbara.

Santa Clara County

Dental Hygienist: Salary range, $322-$392, plus eight cents mileage allowance. Position available in the Santa Clara County Health Department. Applicant must possess California license as a dental hygienist. For further information write W. Elwyn Turner, M.D., Director, Santa Clara County Health Department, 2220 Moorpark Avenue, San Jose 28.

Air Sanitation Laboratory Chief Named

Harold L. Helwig, Ph.D., has been appointed chief of the Department's new Air Sanitation Laboratory, effective February 1st. Dr. Helwig is a native of Michigan where he obtained his B.S. degree from Michigan State University. He completed his doctorate in 1951 at the University of California and was associated with Donner Laboratory on the university campus until 1953. From 1953 until joining the State Department of Public Health, Dr. Helwig was chief scientist in the radioisotope service, Veterans Administration Hospital, San Francisco.

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